Wyoming Department of Health
Commit to your health.

DIVISION OF HEALTHCARE FINANCING
APPLICATION FOR CHILDREN'S MENTAL HEALTH WAIVER (CMHW)
A Medicaid home & community-based waiver

Please type or print CLEARLY.

Date Received _____ Initials _____
Demographics complete? Y N
Clinical LOC complete? Y N
CASII included? Y N
CHIPRA/CME? ☐ Y ☐ N
° FOR OFFICE USE ONLY ° FOR OFFICE USE ONLY °

Name of Applicant	**Date of Birth**	**Age**
Applicant's Home and/or Mailing Address, City, State, Zip Physical Address Mailing Address	**Social Security Number**	

Preferred Language of Communication	**Gender**	**Phone Information**
English Spanish Other	Male Female	Home: ( ) Mobile/Cell: ( ) Work: ( ) Other: ( )

Applicant's location <u>at time of application</u> *(if not at home, please list complete address)*

Home
Residential treatment center _____
In-state mental health facility _____
Acute care hospital _____
Juvenile detention/correction facility _____
Other: _____

Medicaid Information

Is applicant currently enrolled in Medicaid? Yes No
If **Yes**, Medicaid Recipient Number: _____ Effective Date: _____

Is applicant currently enrolled in Kid Care CHIP? Yes No
If **Yes** Kid Care CHIP Number: _____ Effective Date: _____

Please note that if an applicant has Kid Care CHIP and is accepted to the waiver, the family must choose one coverage type. If eligible for the waiver, staff will outline the differences.

Name of Responsible Adult	**Is Applicant currently receiving wraparound services?** Yes No Program? _____

Relationship to Applicant *(if guardian, include a copy of the guardianship order/court documents)*

Parent Guardian Grandparent Other Family Member DFS Custody Other: _____

Adult Home and/or Mailing Address, if different than Applicant <u>Physical Address</u> <u>Mailing Address</u>	**Adult Telephone Number** Home: ( ) Mobile/Cell: ( ) Work: ( ) Other: ( )

EMAIL Address (Participant, ***if 18 and older without guardian or*** **Adult)**

I agree to participate in assessments/screenings to determine eligibility and the need for Care Management Entity (CME) services.

I authorize the release of information by my physician, hospital, community mental health center, other social service providers, school, health service providers and family members to and among State agencies and their agents on my child's medical condition and other relevant information necessary to determine appropriate home and community-based services for the CME.
I understand I may revoke this release of information in writing at any time.

Signature of Applicant/Parent/Guardian/Responsible Person	**Date** ***(month/day/year)***	**Time** **AM** **PM**

Signature of Witness *(required ONLY if the signature of applicant is an "X")*

Signature/Title of Individual Assisting in Completing Application *(see page 3; part 4)*

Part 2 – Clinical Level of Care Assessment – PRINT CLEARLY

MUST be completed by a Qualified Mental Health Professional (QMHP)

1. **Is the applicant between the ages of 4 and 21 years old?** **Yes** **No**

2. **Does the applicant have a current version DSM Axis I or ICD *mental health* diagnosis?** **Yes** **No**

   Code number(s) and primary *mental health* diagnosis: _____
   Date of most recent *mental health* evaluation: _____

3. **Does the applicant (ages 4 through 17) meet the definition of Serious Emotional Disturbance (SED)?** **Yes** **No**
   OR
   Does the applicant (ages 18 and over) meet the definition of Serious and Persistent Mental Illness (SPMI)? **Yes** **No**

4. **Please provide confirmation that the applicant/enrollee meets at least one Medicaid Criteria (below) for needing, or, is at risk of needing (within one month) services rendered in an inpatient psychiatric facility:**

   Persistent, pervasive and frequently occurring oppositional/defiant behavior

   Reckless and/or impulsive behavior, which represents a disregard for the well-being and/or safety of self/others

   Aggressiveness and/or explosive behavior

   Gestures with intent to injure self/others, which have not resulted in serious injury, without evidence that such gestures are immediately progressing to life threatening behavior

   Self-induced vomiting, use of laxatives/diuretics, strict dieting, fasting and/or vigorous exercise

   Extreme phobic/avoidant behavior

   Extreme social isolation

   History of repeated life threatening injury to self/others, resulting in acute care admissions within the past 12 months

   Does the applicant meets at least one Medicaid Criteria (below) for needing, or, is at risk of needing (within one month) services rendered in an inpatient psychiatric facility?
   IF one of the items above is checked, THEN YES is the appropriate answer for this question. **Yes** **No**

   Note: The Children's Mental Health Waiver is a home and community-based service waiver – not a hospital authorization program. The information provided in this application is not used to support hospitalization.

Can the applicant be safely served in his/her home, school, and community with waiver services in place? **Yes** **No**

Does the applicant have a current (within the last year) evaluation with a mental health diagnosis? **Yes*** **No**
* If YES, please include a copy of the evaluation with this application for services.

CLEARLY PRINT the required information of documenting Clinician:

Name and Credentials: _____ License Number: _____
Agency: _____
Contact Telephone Number: (_____) _____ Contact Fax Number: (_____)_____

Clinician Signature: _____ **Date:** _____

REQUIRED for Processing:

- ✓ **Completed application & Level of Care document signed and dated by clinician**
- ✓ **Completed CASII/ECSII tool and scoring sheet (A list of current CASII Providers is available at: http://health.wyo.gov/ddd/ChildrensMentalHealthWaiver.html)**
- ✓ **MAIL, FAX or E-MAIL**

To this Address:	**Fax Number:**	**E-mail:**
Division of Healthcare Financing Children's Mental Health Waiver Program 6101 Yellowstone Road, Ste 210 Cheyenne, WY 82002	307-777-6964	lisa.brockman@wyo.gov

Part 3 -- APPLICATION PREPARED BY (this section completed **only if a person other than** the participant/participant's family or participant's guardian filled out the demographics on page one)
Printed Name: Date:
Signature:
Agency:
Address Street: _____ City / State / Zip: _____
Telephone Number: ( )
Medicaid Provider ID or NPI if billing for application assistance: